MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES

October 22, 2003
10:00 a.m. – 4:30 p.m.
Capitol Plaza Hotel
Jefferson City, Missouri

Commissioners in attendance: Gregg Laiben, MD, Kathryn Nelson, James Buchanan, DO, Tomas Cartmell, Deborah Ann Jantsch, MD, Susan Kendig, Nancy Kimmel, Pamela Marshall, Alan Morris, Bea Roam, William Schoenhard, Stephen Smith, MD, Barry Spoon, DO, James Utley, MD, Kenneth Vuylsteke, Tina Steinman, Kevin Kinkade, Lori Scheidt, Scott Lakin after 12:00

I. CALL TO ORDER

Gregg Laiben, Chairperson

Dr. Laiben called the meeting to order at 10:00 a.m. Silent roll call was taken. Dr. Laiben thanked Governor Holden for creating the commission established for patient safety. Dr. Laiben introduced Governor Holden.

Governor Holden

Governor Holden thanked the commission. He told them they had the opportunity to address the high cost of medical malpractice insurance by reducing the number of medical malpractice claims. He told the panel that they represent the role of citizen input into the democratic process. He asked the commission to do what is in the best interest of the people of this state.

II. OPENING COMMENTS

Gregg Laiben, Chairperson

Dr. Laiben told the commission that there might be a need to hold meetings more than once a month. He then gave his PowerPoint slide presentation on the "framework" or history of patient safety. (Handouts of the presentation are available.) In closing, he stated there are serious problems in healthcare quality. He suggested the cause might be due to poor systems, not bad people. Current systems generate 44,000 to 98,000 deaths per year. The system will require changes. "Dr. Laiben discussed that research shows for every adverse event in medicine, there are almost 300 near misses. He told the commission that health care providers need to find the cause of these near misses and work to prevent them.

Dr. Laiben talked about the work of the nuclear power industry in improving safety and how the lessons learned there are being used to improve patient safety in health care systems.

Dr. Laiben discussed various types of medical errors. He cited, as an example, a significant medical error caused by poor handwriting on a prescription.

Dr. Laiben talked about the commission's charge and stated that error reporting systems would probably be a topic for discussion. He said the commission will hear from people about best practices in patient safety. He told the commission that tort reform will not be part of this commission's work, as it is being discussed in other forums.

Dr. Laiben said the commission will be judged by its recommendations. Dr. Laiben asked each member for their thoughts on what they felt should be addressed in order to improve patient safety."

Kathryn Nelson, Vice-Chairperson

Ms. Nelson said health care providers must acknowledge that humans will make mistakes. We must make it easy for health care professionals to do the right things. Ms. Nelson discussed a project wherein pilots from the airline industry are training health care clinicians to work together as a team. Airline pilots put "Mission Critical Information" on a written checklist, which moves the focus from reliance on human communication to a system. Ms. Nelson encouraged the voluntary reporting of errors. She said health care is at a point where we must make a commitment to learn from past events. Ms. Nelson mentioned pilot projects on patient safety at the Department of Health and Senior Services, at St. John's in Springfield with Vanderbilt University and UMC's electronic voluntary reporting system as models that should be considered. She presented a PowerPoint slide show. (Handouts of the presentation are available.)

III. The commissioners were invited to give their thoughts on issues and ideas the commission should consider as it moves forward. This is a summary of each commissioner's statement:

Tina Steinman, ex-officio member

1. Improve communications between providers, patients, and the public
2. Treat licensed professionals fairly and use error information to improve practice

Lori Scheidt, ex-officio member

1. Track complaints by category, sharing information globally to identify root causes
2. Track complaints not to create a "black list", but to improve patient safety
3. Examine delegation of authority and scope of practice issues

Kevin Kinkade, ex-officio member

1. Operations and quality assurance
2. The commission needs to remove the fear of reporting errors, look at civil liability issues and the freedom to report errors
3. Review Missouri's Peer Review Law and look at expanding it's protections to other health care settings
4. Increase public education
5. Implement the use of current technology, enhanced technology to decrease errors

6. Improve communication between all health care professionals and their patients

Stephen Smith
1. Establish protocols, i.e. for airway management
2. Train professionals to use the protocols
3. Communications between physicians to all members of the health care team
4. Better documentation
5. Improved technology, both current and evolved
   (Dr. Laiben noted that anesthesiology is a leading field in the adoption of protocols.)

Nancy Kimmel
1. Address patient safety in medical education in the classroom
2. Incorporate the patient into the healthcare team
3. Improve patient education
4. Build proactive approach to system failures
5. Capture events as they happen. Health care professionals don't always know an error has occurred early on with a patient

James Buchanan
1. Improve medical school cirriculum education on patient safety
2. Educate the patient on medication and surgery
3. Explore how the medical field disseminates information
4. Educate lawmakers, as they must learn about health care issues

Thomas Cartmell
1. Address breakdowns in communication between nurses, doctors, and other specialty areas in hospitals
2. Find ways to improve relationships within hospitals of professionals from different specialties so all are more comfortable to report errors
3. Expand education after adverse events, from specific medical field to other specialty areas

Deborah Jantsch
1. Educate the public and legislators with regard to the difference between true errors and unfortunate medical outcomes
2. Develop a risk management protocol that will get doctors premium credit on medical malpractice coverage
3. Set up processes and checklists, though the process of doing so can be difficult

William Schoenhard
1. Create a non-punitive environment, invite reporting, identify process and system failures, evaluate near misses
2. Surface, replicate and share best practices to enhance process improvement
3. Create an environment where people are comfortable with systems and processes and retain good staff

4. Create public/private partnerships to build on work already in progress

James Utley

1. Raise awareness among professionals that professionals cannot be perfect and do not always know everything that has occurred. Sometimes professionals think we are practicing safely but find out later we were not
2. Develop systems and good communications
3. Review the cost issues of related to not addressing patient safety problems
4. Peer review
5. Do not try to reinvent the wheel, follow the best practices
6. Explore what is causing problems to rise to the level of severity that malpractice claims result
7. Must report errors and create an openness for reporting errors

Alan Morris

1. Examine the "Sign your site" project, to identify a surgical area (mandated in New York and is free of cost and prevents malpractice)
2. Process improvement, but do not reinvent the wheel, follow the best practices
3. Review the thirty (30) safe practices of the National Quality Forum and look at Leapfrog work
4. Improve communication with the patient by encouraging the patient to become part of the healthcare team
5. Explore the use of computerized physician orders (VA hospitals use)
6. Improve patient education

Kenneth Vuylsteke

1. Explore premium credits in malpractice insurance for adoption of certain protocols
2. Explore marking surgery sites, which is cost free
3. The commission must balance patient's rights with the medical community's need for openness to encourage reporting of errors

Susan Kendig

1. Concern about the twenty two (22) year statute of limitations for OBGYN care
2. Look at putting in processes in place like diagnosis, management, and follow-up with patients to prevent poor outcomes
3. Quality improvement should be a bigger part of formal medical, nursing education
4. Explore the development of evidence based guidelines
5. Work to improve communications among healthcare professionals in different specialties about each patient
6. Link communications to settings outside the hospital setting to provide appropriate follow-up for patients upon discharge
7. Understand the scope of practice of the healthcare team members. Explore the role nurse practitioners might play in preventing errors

Barry Spoon

1. Look at using Vanderbilt and St. John's model. Board of Healing Arts might track and identify professionals with low patient satisfaction scores. They would then be set up with mentoring, with a goal of teaching the physicians how to better communicate with their patients and avoid later malpractice claims
2. Improve communications between doctors and patients (two-way street)

Pamela Marshall

1. Use current technology, including scanning and scales in pharmacies
2. Voluntary error reporting, but solely for educational purposes, not for punishment
3. Look at training other professionals about pharmacy
4. Mandate electronic prescriptions. Faxing, e-prescriptions, but eliminate handwriting which may result in errors
5. Enhance the role of the pharmacist in patient counseling and disease, State mangement

Bea Roam

1. Create a procedure for patients and providers to communicate in the event there is a bad outcome or error
2. Remove the fear of the patient to communicate with doctors and nurses to insure errors are recorded and corrected
3. Create a publicly accessible resource that reports on errors, quality and centers of excellence, possibly creating a report card on providers

Break for working lunch (12:30 p.m.)

IV. SUNSHINE LAW PRESENTATION

Kevin Jones, Assistant Director, Missouri Department of Insurance

Presented basic information the commissioners need to keep in mind with regard to Missouri's Sunshine Law. (A presentation outline is attached.) He reminded commissioners that a booklet produced by the Attorney General's office is part of their packet. Several Commissioners presented questions:

Q: What is the definition of a "meeting"? Does a conference call constitute a meeting?
A: A meeting is a quorum of commissioners that meet for purposes of conducting commission business. A quorum is 9 commissioners. A conference call that met these conditions would be considered a meeting.

Q: Are commissioner's personal notes considered to be "draft minutes"?
A: No.

At this point, the commissioners were asked to contact Linda Bohrer of the Missouri Department of Insurance immediately if they are presented with a Sunshine request, so that the Missouri Department of Insurance can meet the three-day deadline for responding.

Q: Are subcommittees, if named, subject to the Sunshine Law?
A: Yes. If a subcommittee is appointed and meets to conduct official commission business, it must follow the Sunshine Law regarding posting meeting notices, etc.

Q: How are votes recorded? Is each commissioner's vote recorded?
A: The commission has the discretion to decide if public meeting votes will be recorded simply as a count of yea's and nay's, or if a roll call vote will be recorded. Written ballot votes are required for any closed meetings.

V. COMMISSION HANDBOOK / HOUSEKEEPING ISSUES

Linda Bohrer, Division Director for Consumer Affairs, Missouri Department of Insurance

Welcomed the commission members. She is the designated contact person for any administrative needs of the commission. The handbook is subject to updates and additions that will be dated for easy recognition. Each commissioner was asked to fill out the sheet for public contact information. A clean copy of a Curriculum Vitae (member bio) is requested for each commissioner. The Missouri Department of Insurance and other State agency contact persons were briefly introduced. Expense account information needs to go to Diane Springs. Missouri Department of Insurance policies on allowable expenses will be followed. A copy is provided in the handbook.

Andrea Routh, Assistant Director for Market Regualtion and Consumer Affairs, Missouri Department of Insurance

Thanked the commissioners and the Missouri Department of Insurance staff. Andrea introduced the Missouri Department of Insurance Director, Scott Lakin. Andrea briefly talked about the current Missouri patient safety projects and invited commissioners to provide additional information they might have on other projects. A member brought up the Vanderbilt Study. Commissioners were asked to give some thought to prioritizing and categorizing the issues that each member raised during the morning introductions, to be included in possible future agendas. She reminded members that contact information and resumes would become public information.

VI. COMMISSION OPERATING PROCEDURES AND FUTURE MEETING DATES

Gregg Laiben, Chairperson

Dr. Laiben reviewed the commission's draft operating procedures.

- Voting: The Commissioners were asked what they preferred in terms of recording votes for public meetings. Dr. Morris asked for simple counts of yea's and nay's. There were no objections. Dr. Laiben noted that the will of the group is to record a count of yea's and nay's for public meetings.
- Proxies: No substitutes are allowed for commissioners, for purposes of official attendence and voting. If a commissioner cannot attend, a representative can be sent to listen on behalf of that commissioner. No absentee voting will be allowed. There was some discussion about voting via conference call. Kenneth Vuylsteke noted that each

commissioner chose to accept their commission appointment, concluding the commission should expect commissioners to attend as many meetings as possible.

- A motion was made by the commission to adopt the procedure that absent commissioners may not vote. The motion was seconded. The motion was approved.
- The Sunshine Law was discussed again. Commissioners who talk individually to the press are not speaking on behalf of the commission. Commissioners were told that they should get the contact information for any person making a Sunshine request, and pass that along to Linda Bohrer at the Missouri Department of Inusrance. Alternatively, provide Linda's contact information to any person making a request.

- Randy McConnell was introduced. He us the "Public Information Officer" for the Missouri Department of Insurance. His contact information will be added to the "Staff" tab of the handbook and he will serve as point person for press contacts for the commission.
- Minutes will be taken during the meeting. Commission meetings will be recorded for purposes of ensuring accurate minutes; they will not be transcribed. Minutes will be available for approval by the commission at the next meeting.
- Travel in bad weather: Meetings will not be rescheduled or postponed. If a quorum is not present, votes will not be taken.
- Subcommittees may meet via phone, but they will be subject to the Sunshine Law and public notice requirements.
- Requests to present to the commission were discussed. Dr. Laiben stated that the commission hopes to hear from as many people as there is time for, but noted that time is limited. Commissioners who get requests to present should pass the request along to Linda Bohrer. Commissioners were asked not to tell requestors they would definitely be provided the opportunity to make a presentation. Scheduling additional meetings was discussed. It was decided that the commission would meet twice a month, on the following Wednesdays:

  November 5 & 19
  December 3 & 17
  January 7 & 21
  February 4 & 18
  March 3 & 17
  April 7 & 21
  May 5 & 19

- The commission will decide at each meeting if the next scheduled meeting needs to be held or not. The Missouri Department of Insurance will be responsible for sending reminders and RSVP cards. Commissioners were asked to RSVP so that the chair and Vice-Chair will know if they can expect a quorum.

VII. DEPARTMENT OF HEALTH AND SENIOR SERVICES

Commissioner Richard Dunn was unable to attend.

Lois Kollmeyer of DHSS gave the PowerPoint slide show in his absence. (Handouts were provided.) She expressed her agency's interest in training providers on the regulations for Health Standards and Licensure. She asked the commission to address more open communication because many complaints seem to arise from the public's inability to get a facility to respond to them and give them information about adverse events. The floor was opened for discussion.

Q: Does Missouri regulate point-of-care lab testing?
A: Yes, through the CLIA program.

Q: If the State gets a hospital complaint, is the provider usually already aware of the problem?
A: Yes.

Q: What do complainants want?
A: Usually they want a correction so the problem doesn't happen again. They want answers about what has happened. They don't usually want to sue.

Q: Are most complaints in the category of "failed communication"?
A: Anecdotally, yes. Facts are difficult to verify. Therefore, the facility cannot address allegations and families feel like problems aren't addressed by the facility. Many complaints are related to service, rather than quality of care. Example, a patient call light wasn't answered quickly enough.

Q: Does the commission need to deal with nursing homes and other non-hospital settings?
A: Yes. The commission will look at patient safety across many health care settings. This will be discussed further.

Comments - That is a significantly broader topic than safety in hospitals, and is not typically the subject of medical malpractice suits. In open discussion, Ms. Kollmeyer answered a question concerning MRI's, stating that they are not regulated by DHSS. She also explained that DHSS does take anonymous phone calls and complaints.

VIII. THE MISSOURI STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

Tina Steinman, Executive Director, presented a PowerPoint slide show. (Handouts were provided.) She discussed the professions that are regulated by the board, funding, licensure requirements, and the renewal process. She explained the investigative process taken by the board in the event a complaint is received, and the actions that may be taken. She discussed appeals and ciruit court stays. The floor was opened for discussion.

Serving as a member on the Board of Healing Arts, Dr. Spoon responded to a few of the questions that were asked. He stated the Board of Healing Arts tries to rehabilitate physicians, but some other states do not take that approach because they may not value

physicians to that extent. He said the board does review and examine complaints, although some cases may linger on as long as nine or ten years.

Tina Steinman and Dr. Spoon answered the following questions:

Q: Is the testimony at the hearing public?
A: Yes.

Q: Does the Board license physical therapists, occupational therapists or chiropractors?
A: The Board licenses physical therapists. OTs and chiropracters are regulated by other boards.
A comment was made about ineffective self-policing of doctors.

Q: What is the right number of actions the Board of Healing Arts should be taking?
A: (Tina Steinman asked Dr. Spoon if he would respond to this question, which he did.)
The disciplinary system is extremely cumbersome. Doctors are valuable. The Board takes a pro-active stance, emphasizing education, and rehabilitation instead of discipline, when possible. Numbers are different depending on specialty.

Q: If a medical malpractice case goes through both the courts and the Board, could two different conclusions be reached about whether or not medical malpractice actually occurred?
A: Yes. The legal standards for disciplining a license are different than legal definitions of medical malpractice.

IX. MISSOURI BOARD OF PHARMACY

Kevin Kinkade, Executive Director, presented
a PowerPoint slide show. (Handouts were provided.) He explained the rapid changes in the pharmaceutical industry in the past decade. He spoke on issues that cause medication errors, corrective processes, and the quality assurance program. He stated that three billion prescriptions were written annually in the United States. Mr. Kinkade stated that there is a shortage of pharmacists nationally. The floor was opened for discussion. One of the questions presented was in regards to internet prescriptions. Mr. Kinkade responded by stating these sellers must be licensed in Missouri and the Board of Pharmacy has inspectors that make internet purchases. Internet complaints on drug ads are reported, some of which are foreign country sites. These are reported to the FDA.

Q: Does the Board have jurisdiction over mail order pharmacies?
A: Yes. Fifteen percent (15%) of licensed pharmacies are located out of state.

Q: What is the definition of "excessive" dispensing errors? Is it a matter of culture?
A: Currently the Board relies on a voluntary reporting system as an alternative to discipline.
A refusal to voluntarily report dispensing errors leads to formal investigation/discipline.

Q: What about regulating internet pharmacies?
A: Regulation occurs, but is difficult. Internet outlets still have to be licensed. Many are legitimate. Many are not. One dedicated staff person monitors internet pharmacy business.

Q: Does the Board take complaints from the public?
A: Yes. Sometimes problems with foreign sellers cannot be resolved.

Q: Will procedures change due to the Robert Courtney case?
A: Yes and no. Compounding is a rapidly expanding practice, and the complexity of the compounds is rising. So there are more problems. After Courtney, the Board looked at their ability to have intervened, and looked at rules on compounding and sterile products. New rules are in effect. The Board is glad to have secured funding from the legislature to randomly test compounds, including funds to reimburse pharmacies subject to loss due to taking samples for random testing.

A short break was called after the presentation and discussion period ended.

X. MISSOURI BOARD OF NURSING

Lori Scheidt, Executive Director, presented

a PowerPoint slide show was presented. (Handouts were provided.) The floor was opened for discussion.

Q: Who regulates Certified Medical Technologists?
A: Department of Health and Senior Services.

XI. MISSOURI DEPARTMENT OF INSURANCE

Scott Lakin

Director Lakin thanked the commissioners. He emphasized that good public policy is developed by looking at the facts. He mentioned that the commission was recommended as one step in the Missouri Department of Insurance medical malpractice report to the Governor. Mr. Lakin stated his view of the problems that he felt needed to be addressed by the commission.

1. Patient education and the patient's role in the health care team
2. Communication among professionals
3. Repeat offenders, what happens to them? Is this a problem in Missouri? Can we rehabilitate so we don't lose providers?
4. What is our scope? What about the overlapping issues? For instance, pharmacy errors and systems may affect many settings, including nursing homes.

He asked the commission to be creative in its limited time. He closed by introducing Brent Kabler, PhD, as a researcher with a national reputation.

Brent Kabler, Statistics Section Manager, Missouri Department of Insurance

Dr. Kabler presented a power point slide show to discuss the Missouri Department of Insurance's Medical Malpractice Report which was released in February, 2003. He pointed out that Missouri is one of only a few states that collects medical malpractice data from insurers. Missouri has been collecting this data since 1987 so we have some long trending information.

Dr. Kabler noted that the increases in premiums health care providers have seen in the last few years are in part due to increases in losses by medical malpractice carriers. Dr. Kabler explained that such losses are sometimes explained by two competing theories. Some say losses have increased because juries are more inclined toward large damage awards in medical malpractice cases. A competing explanation is that the losses are what we might expect, given general inflationary trends, medical inflation, and wage inflation.

Dr. Kabler said that the MDI data indicates that the long term trend in is that the number of medical malpractice claims in Missouri has declined (closed claims with payments, and closed claims in general).
Average claim payments have increased, though. Dr. Kabler explained that this is due to the economic damages portion of awards (medical costs and lost wages) rather than non-economic damages (pain and suffering). The Missouri data shows that the non-economic damages portion of awards has declined as a percentage of the awards/claims paid.

The economic components of claims have increased because the medical costs to rehabilitate and treat injuries resulting from medical malpractice incidents have increased. Also, lost wages portions of claims have increased since wage inflation has increased.

The third factor, Dr. Kabler said, is the severity of injury caused by alleged malpractice. This severity rating has been increasing over the years.

Dr. Kabler stated that a time series regression analysis on MDI's data indicates there is no other residual factor, besides the three mentioned here, that is contributing to the increase in indemnity awards/claim payments in medical malpractice losses.

Q: Would time series analysis get the same results if we had fifty years (50) of data?
A: Impossible to say, since it would depend on data that doesn't exist. Recall that rates are not tracking losses in the short term.

Q: What is "lost wages"?
A: Wage inflation is greater than general inflation. Rise in lost wages is not an indication that richer people are pursuing litigation.

Q: Can you separate out wage inflation?
A: Yes, and you have medical inflation and severity of injuries left over.

Q: How is payment for lost wages known to MDI?

A: It's part of the required reporting from med mal carriers.

Q: Are more cases settling than going to trial?
A: Will have to opt back to the commission on this. Not sure our data indicates.

Q: Can anyone else explain the rising severity of injuries? Is it due to specialization among attorneys?
A: (from Thomas Cartmell) Yes. Attorneys are less likely to take a case unless a severe injury is obvious. The number of frivolous cases is down because lawyers know not to take them and are more experienced at evaluating cases being settled. The cost of experts is way up so attorneys may not take smaller cases.

Q: Are there statistics on the severity of cases being settled?
A: (from Thomas Cartmell and other commissioners) Yes. Insurers are very selective about which cases they will defend in a trial.

Q: What does MDI data say about the practice of medicine?
A: Says that tort reform as currently proposed won't result in lower medical malpractice premiums. Patient safety improvement efforts to address the underlying issues are the only avenue that will work.

Q: Can med mal data be used to construct a taxonomy of errors? Would that help give the commission something to focus on?
A: Steps have been taken in that direction, although current reporting requirements are insufficient. An error code based on National Practitioner Database guidelines has been added.

Comment: Vanderbilt does analysis on each claim against them. Data is housed in "peer review" and so isn't public, but some has been voluntarily published.

XII. PUBLIC COMMENT SEGMENT

The Chair called for any public comment. There was no public comment given.

XIII. CLOSING COMMENTS FROM COMMISSIONERS

- Dr. Morris asked what Vanderbilt is doing to determine root causes of errors. The National Orthopedic Society has been doing closed claims analysis for years, but not on root causes.
- Kathryn Nelson responded that Vanderbilt's progressive risk management decided that all claims would be classified under root causes. That's where current work on doctor communication grew from. More complaints equates to more liability.
- Bill Schoenhard remarked again on his preference for public/private partnerships, and that the task before the commission is enormous. He asked if examples from other states were available.
- Kathryn Nelson responded that there are 17 other states that she knew of with some sort of patient safety committee or commission.

- Gregg Laiben pointed out "Tips for Success" from another state's commission. It stated that Tip #1 was not to reinvent the wheel.
- Deborah Jantsch asked the commission to plan on the desired end product to provide direction.
- Kathryn Nelson said to think about the scope and presentations or data that commissioners want to see. Also, commissioners should think about their vision for Missouri. Each commissioner should write down his or her own vision for what Missouri would look like if patients are safe.
- Gregg Laiben noted that the location of the next meeting is to be announced. A packet from MDI will be sent in advance.
- James Utley stated that where we want to be should be based on a good look at where we are.

XIV. MOTION TO ADJOURN

Motion to adjourn was made, seconded, and approved. The meeting was adjourned at 4:35 P.M.